

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN671HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/23/2009
NAME OF PROVIDER OR SUPPLIER WILLOW SPRINGS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 690 EDISON WAY RENO, NV 89502		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	<p>Initial Comments</p> <p>Surveyor: 13812 This Statement of Deficiencies was generated as a result of a resurvey conducted in your facility on 10/23/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. The resurvey was conducted to ensure compliance as a result of the findings during State licensure survey conducted on 8/13/09.</p> <p>There were no regulatory deficiencies identified during the survey.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	{S 000}		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE